TIME 11:38 AM DATE 9/11/2014

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name:
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: Age: Soc. Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg.:

Section 3

Credit Card:

EXP DATE:

Type of card:

Ins card copied:

Employee Name:

Ins. Effective Date::

Date ins was verifie:

Primary Insurance Information

Name of Insured: Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City,State,Zip: City,State,Zip:

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City,State,Zip: City,State,Zip:

Rem. Benefits: .00 Rem. Deduct: .00

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

MARIETTA SMILES FAMILY & COSMETIC DENTISTRY
175 White Street, NW
Suite 300
Marietta, GA 30060
(770) 422-6521

Patient Authorization for Use and Disclosure of Protected Health Information

Last Name First Name Middle Initial _____ Date of Birth (Month/Day/Year)

Street Address _____ SS#

City _____ State _____ Zip _____ Primary Contact Number

I authorize Marietta Smiles Family & Cosmetic Dentistry to disclose Protected Health Information to the following persons:

□ Spouse _____
Name Phone Number

□ Child (ren): _____
Name Phone Number

_____
Name Phone Number

□ Other: _____
Name Phone Number

Information to be disclosed:

□ All Dental Information □ All Billing/Account Information

Authorization Statement: I understand that protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to Marietta Smiles Family & Cosmetic Dentistry. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that Marietta Smiles cannot require me to sign this authorization as a condition of treatment unless the provision of health care by Marietta Smiles is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand I will be given a copy of this authorization.

Signature/Date: (date authorization signed by patient or Legal Guardian):_____

_____ _____
Print Patient Name or Name of Legal Guardian Signature of Patient or Legal Guardian

_____
Indicate relationship to patient (required)

Marietta Smiles, LLC

Financial Policy and Agreement

Welcome to our office! Our goal is to help remove financial barriers so our patients can receive the dental treatment they need and desire. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

Insurance: Our office is committed to helping patients maximize their benefits. Insurance policies vary greatly. Therefore, owing to the complexity of insurance contracts, we can only estimate in good faith, not guarantee coverage. Your estimated patient portion must be paid at the time service is delivered. As a service to our patients, we will bill your insurance company for services, and allow 45 days for them to render payment. After 60 days, you are responsible for the entire balance and it will be due in full. If you have any questions, our courteous staff is always available to answer them.

You will be informed of the treatment planned and associated fees. Patients are responsible for charges for dental services and materials not paid by their dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with the plan prohibiting all or a portion of such charges. To the extent permitted by law, patients consents to the use and disclosure of protected health information to carry our payment activities in connection with filing the dental insurance claim(s). By signing below you are authorizing direct payment of dental benefits, otherwise payable to you, directly to Marietta Smiles and its authorized dentists.

Payment Options: Patients are asked to pay for services as they are provided. We accept cash, checks, and most major credit cards (MasterCard, Visa, Discover and American Express). We also offer flexible financing options because we understand that monthly payments can help patients fit the costs of dental treatment into their budgets.

CareCredit®Financing: We offer financing through CareCredit® for those who qualify. With CareCredit®, you can finance 100% of your dental treatment and there are no upfront costs, no annual fees, and no pre-payment penalties. CareCredit® also allows for revolving payments with a variable interest rate and up to 12 months of 0% interest. It can be used by the whole family for ongoing treatment without having to reapply, too.

Missed Appointments: We schedule one patient per appointment, because you deserve exclusive, personal time with our doctors and staff. We strive to run on time so you won't be kept waiting, and we ask you to arrive for your appointments on time as well. We understand that you are busy and your time is valuable to us! We pride ourselves on keeping to our schedule and only deviate from it in the event of dental emergencies.

Please call at least two business days in advance for changed appointment. Missed appointments without this notification, or repeated cancellations, may incur cancellation fees. We want to work with you to schedule convenient appointments for your visits to our office.

Service Charges: The policy of this office is to charge 1% monthly interest (12% annual percentage rate) or a billing charge that will be applied to all accounts over 90 days past due. We will charge $35 for returned checks.

Collection Fees: Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Financial Consent: The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement

_____ _____

Signature of Patient/Responsible Party Date

175 White Street, NW, Suite 300 • Marietta, GA 30060 • Phone: (770) 422-6521 • Fax: (770)422-6525
www.mariettasmiles.com

Marietta Smiles
Dental History

Last Name _____ First Name _____ ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

Address _____

City _____ State _____ Zip _____

1. Date of last dental visit ? _____/_____/_____ Date of last dental xrays? _____/_____/_____
2. Reason for last visit? _____
3. Do you have any concerns about previous dental care or this dental visit? _____
4. On a scale of 1 to 10 (10 being the highest) how important is it for you to keep your teeth for the rest of your life? _____
5. Are you happy with your smile? (circle your response) Yes No

   If no, please explain: _____

   _____

6. Do your gums bleed? Yes No
7. Are your teeth loose? Yes No
8. Have you ever been told that you have bad breath? Yes No
9. Are your teeth sensitive to (circle all that apply) Sweets Cold Heat Pressure
10. Do you like the color of your teeth? Yes No
11. Do you feel your teeth are starting to get longer? Yes No
12. Do you get food stuck between your teeth easily? Yes No
13. Do you ever experience tooth pain that is relieved by biting down on the affected area? Yes No
14. What would you change about the condition of your mouth? _____

    _____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers that I have given are accurate. I also understand that it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature _____ Date _____

If you have completed this form for another person, please print your name and sign below along with your relationship to the patient:

Print _____ Relationship _____

Signature _____ Date _____

175 White Street NW, Suite 300 - Marietta, Georgia 30060 - Phone 770.422.6521